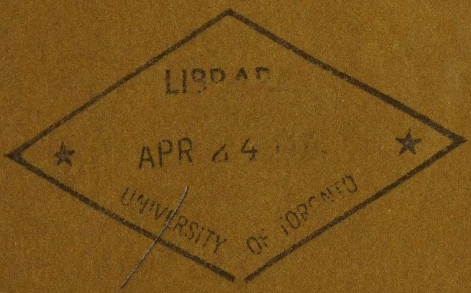
Community Living for the ntally Retarded in Ontario:

A New Policy Focus

March 1973



Ontario

The Honourable Robert Welch, Q.C., LL.D.
Provincial Secretary for
Social Development

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Preface

In March 1972, the Cabinet Committee on Social Development established as a priority the need to undertake a major revision of the general arrangements for the mentally retarded in Ontario. A Task Force on Mental Retardation was set up to document the existing problems, and in February 1973 its findings were presented in an Interim Report to the Cabinet Committee.

On the basis of this and other reports, the Government of Ontario has adopted a new policy focus for the delivery of services to the mentally retarded centred around the concept of community living. The principles underlying this important decision and its implications for present and future planning are outlined in this document, providing a foundation for public discussion of the issues and alternative courses of action.

The Government of Ontario earnestly seeks and welcomes the views, suggestions, and reactions of concerned individuals and organizations. Submissions should be addressed to:

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COMMUNITY LIVING FOR THE MENTALLY RETARDED IN ONTARIO

A New Policy Focus

COMMUNITY LIVING FOR THE MENTALLY RETARDED IN ONTARIO: A NEW POLICY FOCUS

INTRODUCTION

The past decade has been marked by substantial progress in our understanding of mental retardation. As a result of a number of studies published in Canada and abroad, we have come to realize that the problems faced by the majority of the mentally retarded are primarily of a social rather than a medical nature, and that segregation of these persons in isolated institutions is not an adequate, let alone a suitable, form of care. From this awareness a new philosophy has emerged which is now being widely adopted in the planning of the provision of services for the mentally retarded. The guiding principle of this philosophy has been clearly stated in the Williston Report:

> If a mentally retarded child is to be provided with the assistance he needs to face the problems of adult life and is to be given the opportunity to develop to his ultimate potential, he must at all times be given the greatest possible degree of participation in life. Society must maintain for him the maximum degree of normalcy in all of his experiences to allow him a healthy and happy development as a total person (p. 5).

It follows that, wherever feasible, services should be provided in a community setting as an alternative to institutionalization.

The term institutionalization, as used throughout this paper, implies the segregation of the retarded from the rest of society; the provision of care on a large scale, so as to minimize unit costs; and the provision of care in an area that is remote from major urban centres. In contrast, the provision of community services implies the involvement of the mentally retarded with other members of society, in programs that emphasize their needs as individuals, and in large as well as small communities.

Obviously the transfer of the mentally retarded person from a sheltered institutional environment to an open, active community setting requires extensive readjustment of the present delivery system. The problems, though formidable, can be overcome if an effort is made by all responsible government bodies and social agencies to co-ordinate and revise existing and proposed programs. In the pages that follow, we suggest the means whereby this goal may be achieved.

NEEDS OF THE MENTALLY RETARDED

The Williston Report describes the mentally retarded as "persons who are seriously lacking in intelligence and who, because of their subnormal functioning, require special training, education and social services"(p. 5). Because the mentally retarded person is unable to organize his thought processes in an efficient way, he cannot usually function successfully as an independent member of our society.

There are widely different levels of competence among persons who are mentally retarded. Those who are mildly retarded are educable up to about the grade 6 level; roughly 90 per cent of this group are able to hold down jobs with low educational requirements and most can participate freely in the community. Moderately retarded persons can assimilate some very basic elementary education, up to the grade 2 level, and can be employed in a highly structured setting. The severely retarded are uneducable beyond the acquisition of basic social skills, such as use of the toilet and dressing, and they can perform only simple assembly and packaging tasks. Among the profoundly retarded, some cannot be trained at all, and all require care and protection.

Sometimes the problems of mental retardation are compounded by associated physical disabilities, particularly among the severely and profoundly retarded. Many moderately retarded persons have minor brain dysfunction and lack physical coordination.

In spite of this, the fact remains that, except in the case of persons with multiple handicaps and excluding the

possibility of reducing the incidence of retardation through preventive medical services, care of the mentally retarded is essentially an issue of social concern and only secondarily a medical problem.

The need for special treatment of the retarded is easily identified. Most are unable to provide financially for their basic daily needs of food, shelter, and clothing, since adequate earning opportunities are not open to them; and many require an environment that is protective and highly structured. It must be stressed, however, that special treatment does not necessarily imply or demand segregation of the retarded. There are others in the community - the deaf, the elderly, the crippled, and the poor - who can benefit equally from the provision of special medical, educational, recreational, and residential facilities. Programs for care of the retarded therefore should be designed in a broad community context, if they are to achieve maximum effectiveness.

The range of services needed by the retarded may be grouped broadly into nine categories: preventive services, focusing on pre-natal care and diagnosis; case finding, diagnosis, and counselling; developmental care and special education for school-aged children and adults; vocational training; recreational programs; financial assistance; medical, dental, and legal services; and residential and treatment facilities.

The efficiency and effectiveness of delivery systems are affected by the location of these services. A closed institution provides most of them; but since a life of normalcy is our goal in caring for the mentally retarded, a full range of services will have to be provided in the community as well.

PROBLEMS UNDER THE PRESENT SYSTEM

In Ontario today, there are approximately 70,000 residents known to be mentally retarded. Of these, about 8,000 receive institutional care, while the rest receive some form of public assistance or community service.

During the late 1960s, attempts were made to upgrade the existing system of care in Ontario through the introduction of new and revised legislation, including:

1. Establishment (since 1960) of diagnostic and assessment centres by the Ministry of Health;

2. Enactment in 1966 of the Homes for Retarded Persons Act and of the Vocational Rehabilitation Services Act;

3. Amendments in 1967 to the Secondary Schools Act to require school boards to provide services to the trainable retarded;

4. Amendments in 1972 to the Day Nurseries Act to permit grants to nursery schools for retarded children and to developmental day care centres for school-aged (six to eighteen years) retarded children.

Despite these changes, there has been little overall improvement in the actual pattern of care received by the retarded. Between 1963 and 1972, the number of mentally retarded individuals in institutions and in special units in psychiatric hospitals declined by only 10 per cent; and last year, the number of individuals living in community residences comprised only 5 per cent of the total population of institutions for the mentally retarded.

There are several reasons why the movement to care in a community setting has not occurred. Under the existing system, the delivery of care services for the mentally retarded has been shared among six ministries - Health, Education, Community and Social Services, Colleges and Universities, Labour, and the Attorney General. As one might expect, there has resulted a visible lack of co-ordination of programs and goals, reflected most strongly in the division of responsibilities among the ministries of Health, Education, and Community and Social Services.

The Ministry of Health and the Provincial Schools Branch of the Ministry of Education are responsible for the care of the retarded in institutions for the retarded; and the Ministry of Community and Social Services and the local school boards are responsible for the care of mentally retarded persons in a community setting. In practice, very little progress has been achieved in establishing services in community settings: the Ministry of Health has focused primarily on isolated institutions, and to a degree on diagnostic and assessment centres, the Ministry of Community and Social Services has no authority to build and operate such services unilaterally; and local school boards have not been able to extend their services to effectively serve all mentally retarded children in their communities.

Some government policies also appear to be unintentionally encouraging the perpetuation of institutional care. The decision to place a mentally retarded person in an institution depends upon two main factors: the availability in the community of services for all the needs of the individual, including residential care, workshop programs,

protective services, and special education; and the cost, either to the family of the retarded person or to the community, of the utilization of services in the community. Given these conditions, the following policies and practices may be viewed as incentives towards placement of the mentally retarded in an institution:

1. Guardianship services are generally unavailable for retarded adults in the community.

2. The share of capital costs underwritten by the Government of Ontario for any program in an institution for the mentally retarded is 100 per cent; the share of capital costs taken for programs in the community is a maximum of 50 per cent.

3. Capital appropriations for the construction of institutions have been substantially larger than those for the construction or acquisition and renovation of residences in the community.

4. A children's aid society incurs no cost for the placement of a retarded child in an institution but must pay the full cost of placing the child in a community setting.

5. The Ministry of Health pays the total operating costs of institutions. The Ministry of Community and Social Services pays only 80 per cent of the operating costs of community residences; the rest must be contributed by the family of the retarded person, by a charitable agency, or by the retarded adult in the form of a family benefit shelter allowance.

6. The Ministry of Education pays the full cost of education for a child in an institution, but only 58 per cent, on the average, of the cost of educating a child in the community setting.

7. The Ministry of Health pays the full cost of sheltered workshop programs in institutions; the Ministry of Community and Social Services pays, on the average, about 35 per cent of the cost of workshops in the community.

The traditional ministry budgets have reflected these questionable incentives by allowing increases in the institutional sector but restricting the availability of funds for community-centred services.

Even the retarded who live in community settings do not enjoy the full range of benefits and opportunities that should be made available to them. In the first place, they are at a financial disadvantage. They are restricted almost exclusively to work activity in a segregated setting; they receive wages that are below minimum standards; and the workshops that employ them operate at a negative level of productivity. Because there are no incentives for employers to hire mentally retarded persons, despite exemptions from the minimum wage provisions of the Employment Standards Act[1], sheltered workshops are forced to provide the retarded with long-term employment, as well as an environment for rehabilitation. Since employees of workshops are recipients of family benefit allowances, their wages are limited by a ceiling of $24 per month; 75 percent of income that exceeds this figure is used to reduce the amount of the family benefit allowance. And there are no incentives for the workshops to become productive since this would almost certainly reduce the

[1] The employer is allowed to pay the retarded individual a wage below the minimum, but he must include the employee in benefit plans and other employment schemes. In view of the low productivity of the retarded employee, the net cost of hiring him is higher than the cost of hiring a non-retarded person.

operating grants they receive for their function as a care service.

At present, the range of community facilities providing residential care is limited by the regulations of the Homes for Retarded Persons Act. These regulations stipulate the minimum staffing ratio (one staff person for each four residents). As a result, the total cost per resident is quite high ($420 per month). Also, the semi-institutional style of living is unattractive to many residents who would welcome a greater degree of independence. Between the limits of the shelter allowance of $57 per month for completely independent living and living under the auspices of a Home for Retarded Persons, a range of alternatives should be provided which are more appropriate to the needs of many retarded persons.

Finally, the school-aged retarded who live in the community often do not have access to educational facilities such as developmental day care centres, and school boards need only provide services to those children who will benefit from their program. As a result, there are some retarded children for whom no day-time activity program is available.

As a necessary precondition to a life of normalcy, in both institutional and community settings, mentally retarded persons must be encouraged and allowed to make their own decisions and determine their own needs, as far as this is possible. A major fault of the present system of care is that a considerable amount of money is spent <u>for</u> a retarded person, but its use is generally

not controlled by that person, his family, or his guardian.

Currently, functional services are provided in settings geared to the highly visible needs of the most severely handicapped. These services are not necessarily appropriate for moderately handicapped persons. Thus, there are a large group of mentally retarded persons who must submit to a highly structured care system which may frustrate their desires for more independence, or encourage them to forego all care entirely. In either case, services geared to the needs of this group are being neglected.

ALTERNATIVES AND THEIR IMPLICATIONS

If community services are developed to permit the transfer of institutional residents back to their communities, these services will also attract the retarded who are now living in the communities but receiving no special services. This probability must be taken into account in assessing the cost of initiating and developing programs. It is almost certain that the use of community services will exceed the use of services offered under the present system.

Also, it must be emphasized that the mentally retarded are only one segment of the handicapped population in Ontario; their needs cannot be considered to the exclusion of the needs of others. When a practical system of care for the retarded is developed, it will have to be judged in terms of its possible extension to other handicapped persons. This too will have an important bearing on the assessment of costs.

In effecting a transfer of the mentally retarded from the institution to the community, the focus of change must be directed to four interrelated areas:

1. Guardianship and protective services for retarded adults must be provided in the community.

2. Resources devoted to residential care and counselling must be reallocated from the institution to the community.

3. Manpower and welfare policies must be developed that attempt to integrate the employment opportunities of retarded persons with those of the general population.

4. The services required by the retarded person in the community must be provided through a coordinated program.

The development of services in certain of these areas will require a greater concentration of effort and resources than in others. But none of the four should be treated as a priority above the rest; change must encompass them all, or the provision of care in the community will be less than adequate to meet the needs of the retarded.

1. Guardianship and Protective Services

Responsibility for the guardianship and protection of retarded adults may be delegated to a number of individuals and bodies. Each alternative has its advantages and disadvantages, and these should be examined in some detail.

Ideally, of course, the family of the retarded individual can provide him with the most familiar and most socially reassuring environment, with minimal additional costs imposed on the community. It does tend to place an extreme financial and emotional burden on the family, however, and it does not necessarily encourage the social development and adjustment of the retarded person.

At the opposite extreme, the individual may be admitted to a closed institution. Although this provides him with a perfectly safe environment and affords him access to a wide range of treatment and developmental services, he is subjected to all the disadvantages of institutional care. In addition, the family of the retarded person has little control over his treatment in such a setting.

Between these extremes lie several other choices. A public trustee and legal guardian of a retarded person may accept responsibility for his care. The role of diagnostic and assessment clinics for the mentally retarded may be extended to include guardianship, although this may be prohibitively expensive in terms of increased staffing and expansion of facilities.[2] Guardianship services may be purchased from a local agency through the regional offices of the Ministry of Community and Social Services. Or a local board may be set up in major population centres throughout the province to coordinate services for the mentally retarded and possibly to assume responsibility for guardianship as one of its functions. The last two alternatives are being tested in pilot projects in Ontario and seem to be promising alternatives for meeting this need.

2. Reallocation of Resources for Residential Care

The lack of residential care in a community setting is a serious deficiency under the present system of care for the retarded. Feasible programs for the provision of this service range from unstructured facilities, such as the individual's home or an apartment unit, to highly structured facilities, such as institutions. Some residential services are more suitable than others for individuals with different levels of impairment, and each program must be considered in terms of the need in particular cases, as well as in terms of its relative costs.

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[2] Under present legislation, these clinics are not eligible for cost-charing under the Canada Assistance Plan.

Again, ideally the individual may live with his family. If financial support is provided under the Family Benefit Act ($1,620 annually for a retarded adult), the burden of cost is alleviated; but there is no way of ensuring that the family in fact uses the money for support and care of the retarded person. Also, in this environment, the individual's opportunities for social and skill development are generally very limited.

Another alternative is to place the individual in his own apartment, where access to counselling is provided. This is an attractive choice for retarded individuals who are capable of functioning independently with a minimum amount of supervision. The provision of this type of accommodation is relatively inexpensive (about $1,300 annually in addition to the Family Benefit allowance) as compared with more highly structured facilities; but it is appropriate for only a small proportion of the mentally retarded, and there is some risk that the environment may not be sufficiently protective to suit the resident's long-term needs.

Foster homes provide an environment that resembles the family setting, and they are not expensive to administer (about $2,000 annually). Extreme caution must be exercised in matching retarded individuals and their prospective foster parents, however, to ensure that the arrangement will be viable for both parties. The main difficulty is in finding such suitable accommodation for retarded adults.

There are two types of more structured community residences that approximate a home setting: the group home, which accommodates between eight and ten persons; and

the larger community residence with more than 20 residents. Both provide access to outside activities. The cost of the smaller home is about $4,600 to $4,900 per person annually, and of the larger residence, about $6,000 to $6,300. Both are eligible for cost-sharing under the Canada Assistance Plan, and very attractive CMHC mortgage terms may be arranged for the purchase of the facilities. One of the benefits of this type of residence is that it separates residential activities from work and education, and at the same time offers the retarded individual the companionship of his peers. Among its disadvantages are the removal of the individual from his home, the added expense of providing this facility, and the problem of conflict with municipal by-laws in some communities. In the case of the larger residence, the community may reject the retarded individuals because they form a concentrated group.

Finally, there are two institutional options. The community-based institution provides all care and services, as well as ready access to the community. Its location facilitates visits from family and friends, and it may reduce staffing problems. The remote institution also provides complete services, but isolates the individual from social contact. It is more expensive than the community-based institution (about $7,000 annually as compared with $5,300 to $5,600), and it is plagued with staffing problems because of its isolation. Neither institutional facility is considered a suitable long-term solution to the problems of caring for ambulatory retarded persons. However, there are two reasons for continuing to develop the community institutions at Oakville, New Toronto, Aurora, and Sault Ste. Marie. (Proposals for Windsor, North Bay, Sudbury and

Hamilton are not yet in the development stage.) First, these institutions will provide a transitional facility for helping the residents of the Ontario Hospital Schools at Orillia, Smiths Falls and Cedar Springs to adapt to community living before the full complement of necessary community resources can be developed. We do not believe that parents of retarded persons now living in large, remote institutions would rather leave them there until the full range of community programs becomes available to replace the present institutions. As the community services become operational, these residents can then be returned to fuller participation in society, consistent with their needs. Secondly, these community institutions will fulfill a continuing need, both for care of the more seriously retarded and multiply handicapped, and for the intensive training required to change dysfunctional behaviour patterns. We must not overlook the plight of mentally retarded persons currently in our remote hospital schools in our attempts to create a better care system for the future.

3. Manpower and Welfare Policies

For most individuals in our society, employment fulfills a security (income) need and provides productive activity. In the case of the mentally retarded, this form of security is provided partially through welfare support and partially through employment. Work activity generally affords low satisfaction. The three main problems in improving this situation are: the support of mentally retarded persons under the welfare system, the exemption of these persons from minimum wage legislation, and the lack of incentives offered to employers for hiring handicapped persons.

The objectives of income and employment policy should be to normalize the relationship between income and employment, as far as this is possible, and to maximize the degree of control that the retarded person, his family, or his guardian has over public expenditure for his support. The range of policies that might be considered is indicated by the following description of alternatives.

First, sheltered workshops may continue to provide income through employment and welfare. Workshops provide a controlled work environment geared to individual abilities; they remove the possibility of exploitation by the employer; and they provide a compatible social environment for the retarded person. On the negative side, they offer little financial incentive. Because the retarded person may not earn more than $24 per month without incurring a reduction in his family benefit allowance, workshop wages are low (between 3¢ and 11¢ per hour) and few workers seek additional employment outside the workshop. Given this low income level, society must provide directly funded residences for the retarded, so that overall costs increase substantially. Costs to the workshop also are high, because of the need for close supervision of the workers, and this results in negative productivity. Finally, the worker receives no employment benefits under the workshop system.

Second, the employment of retarded persons in industry or in workshops may be subsidized. One alternative is to grant industry a subsidy equal to the sum of the disability allowance and the direct subsidy of sheltered workshops (at present $175 per month) for each retarded person employed at a wage rate exceeding the amount of

the grant. Another option is to provide a grant to both industry and workshops for the employment of retarded persons at the minimum hourly wage when their productivity is less than that of a non-retarded person. Under both systems, the retarded person could participate directly in the community's work force; earn a higher income than presently available, at less cost to the government; receive the usual employee benefits; and gain satisfaction from his work activities. Controls would have to be provided to prevent exploitation of the worker by the employer, and special provision would have to be made in work settings where collective bargaining exists.

Third, special provision may be made for the employment of mentally retarded persons in the Ontario Public Service. This too would permit integration of the individual into the community work force, provide him with employment benefits, and improve his work satisfaction. The main disadvantage of this option is that it conflicts with the return to a normal life style for the retarded individual since it limits him to one employer (itself a form of segregation).

4. Coordination of Care Services

There are at least three ways in which care services may be coordinated on a province-wide basis to ensure the delivery of a full range of services to the retarded.

1. A Department or Agency of the Provincial Government may be created that is responsible for the coordination of services to all handicapped persons.

This body would have jurisdiction over the planning, coordination, and implementation of a comprehensive,

province-wide program for the handicapped, including responsibility for setting and implementing standards of services, personnel, and programs; evaluation and recommendations for the allocation of funds; coordination of planning and delivery services; development of technical administrative personnel; and coordination of services and research for the mentally retarded (Williston Report, p. 95). Such an approach could eliminate duplication and fill gaps in the existing delivery system. It would also permit unity of budgetary control, and its programs might be eligible for cost-sharing under the Canada Assistance Plan. However, the Government of Ontario is currently structured to provide services by ministries organized according to function. The need to coordinate functional services to meet the needs of various groups, including the mentally retarded, was one of the reasons for the reorganization of government into policy fields. An alternative organization into ministries serving client groups begs a more difficult task of coordination of function. Creation of a ministry for the handicapped would, in itself, be a form of institutionalization segregating handicapped residents from other citizens of Ontario. Other disadvantages of this approach would be the lack of opportunity for community involvement and for innovation to meet local or regional needs and preferences.

2. Responsibility for all units of institutional care for the mentally retarded, except hospital units, may be transferred to the Ministry of Community and Social Services; hospital units may be reclassified under the Public Hospitals Act.

This system would permit unity of responsibility for residential care of all mentally retarded persons except those requiring special medical attention, and it might

encourage the phasing down of institutional use and development. Also it could be supported by federal cost-sharing under the Canada Assistance Plan and the Hospital Insurance and Diagnostic Services Act. One of the first problems in implementing this system would be to acquire experienced consultants in the Ministry to advise instiutions on administrative problems. It would be necessary to reallocate institutional budgets between the Ministries of Health and Community and Social Services. And placing responsibility for institutions with the latter Ministry may be considered incompatible with its current responsibility to develop and support community-based programs.

3. The role of each ministry now participating in tne provision of care services may be defined more specifically than it is at present, and interministerial cooperation may be increased.

The only change in role required under this system would be the placing of responsibility for personal guardianship with one of the six ministries. The funds available for building and operating community facilities would be increased across the board. This system could encourage a community focus in the provision of services, but it embodies no incentives to ensure that institutional services would be phased down. Also it lacks a single coordinating body to oversee the delivery system.

In addition to these alternatives for coordination at the provincial level, coordination at the community level is possible.

4. A local agency may be incorporated that is responsible for the provision of services to all retarded persons in its community.

Through community participation, this alternative would permit flexibility in the provision of services to the retarded and to other handicapped persons, and would hopefully encourage the community to accept the handicapped individual as a person. It would permit co-ordination of all forms of residential services and would ultimately be less expensive than a centralized system. The disadvantages of this approach are the difficulties in arousing community interest to the point of participation on the board; the need to obtain co-ordinating staff; and the inconvenience of dealing with many agencies of the Provincial Government.

PROPOSALS FOR CHANGE: A SUMMARY

The principal focus of policy planning for the mentally retarded must be the provision of services in a community setting as a primary alternative to institutionalization. From this it follows that remote institutions should be phased down; that, wherever possible, a mentally retarded child should be cared for within a family setting; and that the community environment should encourage the full development of the social and employment potential of the retarded adult.

To facilitate the transfer of the retarded individual from the institution to the community, the Government of Ontario is presently considering ways to implement the following policy decisions:

1. A special program of guardianship and protection should be provided for all mentally retarded adults in the community.

2. Economic incentives that discourage the employment of mentally retarded persons and that encourage the development and use of institutional programs rather than community services should be eliminated.

3. Appropriate residential facilities should be provided in the community to accommodate mentally retarded persons according to their individual needs.

4. Coordinating mechanisms should be established at both the local and the provincial levels to ensure that a wide range of services is available.

Towards the achievement of these goals, the Government

of Ontario intends to adopt the following procedure. The existing Interdepartmental Committee on Guardianship will be asked to report on alternatives for the provision of a complete guardianship service and to recommend the adoption of the most suitable program. The Ministries of Labour and Community and Social Services will be asked to report on the feasibility of initiating a program of incentive subsidies to industrial employers to encourage the hiring of retarded persons. The Civil Service Commission will be asked to report on opportunities for the employment of retarded persons within the Provincial Government. An implementation team will be formed to prepare a plan for the transfer of all rehabilitatable individuals from institutions for the mentally retarded back to their home communities, and to establish criteria for the admission of retarded individuals to the range of community service programs that they need.

Finally, the Government of Ontario wishes to solicit at this time the views, suggestions, and reactions of concerned individuals and organizations in the community. The issues explored in this paper must be publicly discussed if the recent policy changes adopted by the Government are to be accepted and implemented throughout the province. I hope that this paper will play a major role in the discussions which I know will follow, and I look forward with optimism to the challenge of translating our new policy focus -- community living for the mentally retarded in Ontario -- into reality.

- 30 -

Appendix I

Survey of Needs

The services required by a mentally retarded person vary according to his level of competence. Four degrees of impairment can be identified among the retarded.

Table I-1 Classifications of Retardation

Degree of Impairment	Typical IQ range	Prevalence in total population (per cent)	Potential
Mild	50-70	2.5	Educable up to grade 6; 90 per cent can work and live in community with minimum care and supervision
Moderate	32-50	.4	Can grasp basic education up to grade 2; employable in highly structured settings; require residential care
Severe	18-32	.075	Usually can be toilet trained and can dress self; can perform simple assembly and packaging tasks; require constant care
Profound	under 18	.025	Often cannot learn social skills, cannot perform simple physical tasks; require constant protection and care

This estimate of prevalence by degree of impairment is

based on an estimate of the American Association for Mental Disability that 3 percent of the population suffer some form of mental retardation. This level may not be altogether realistic for Ontario, but few data are available to correct the figure. The Northeastern Ontario Task Force found that only 0.5 to 1.1 per cent of the surveyed population could be classified as mentally retarded. Illnesses such as cerebral accidents that result in impairment of mental function are not included in our definition of mental retardation.

Range of Needed Services

The following list outlines the wide range of services needed by the retarded. To the extent that these services are not provided in an appropriate setting, the goal of providing an environment as near normal as possible for every mentally retarded person in the province cannot be achieved.

1. Preventive services
   - Pre-natal care
   - Pre-natal diagnosis
     - aminocentesis and abortion if indicated and desired
     - high-risk registry

2. Case finding services
   - High-risk registry
   - Hospital and home visits of high-risk infants
   - Other investigations:
     (a) In education, the identification of cognitive and perceptual problems
     (b) In health services, routine health examinations of pre-school and school-aged children

(c) In the community, referrals by social agencies such as children's aid societies, vocational rehabilitation agencies, and regional social assistance offices

3. Diagnosis and counselling services

Family and agency assessment and counselling services

Other family counselling services, such as children's aid societies, the Family Service Agency, physicians, and mental health clinics

Genetic counselling

Guidance and home care

4. Developmental care services for pre-school children

Pre-school or nursery school facilities

5. Special education, training, and development services for school-aged children

Special programs for the educable retarded, the trainable retarded, the severely retarded, and the profoundly retarded

6. Continuing adult education services

Programs designed to improve the retarded adult's understanding of the community

7. Vocational rehabilitation services

Manpower development:

(a) Training

(b) Assessment, placement, and counselling

Long-term employment:

(a) Sheltered workshops

(b) Special arrangements with employers

8. Daily activity for retarded adults

Recreation

Sheltered recreation

Activity centres for severely and profoundly retarded adults

9. Financial assistance
   - Allowance to adults
   - Support to the family of the retarded child

10. Protective services
   - Legal problems
   - Counselling
   - Money management
   - Estate management

11. Medical services
   - Higher incidence of concomitant physical disability

12. Dental services
   - Preventive and restorative treatment under anaesthesia

13. Spiritual services

14. Residential care
   - (a) Home support services
   - (b) Boarding homes
   - (c) Family care homes for children and adults
   - (d) Agency community residences
   - (e) Half-way houses
   - (f) Apartments
   - (g) Institutions

15. Special treatment and training facilities
   - Nursing homes
   - Residential treatment and training facilities

Unmet Needs

In relation to the needs of retarded persons, the following services do not seem to be adequately supplied by existing programs:

1. Preventive services

   The program is embryonic.

2. Case finding services

   Severely retarded persons may be identified at birth; others are identified through parental initiative.

   There is no registry of high-risk persons and no subsequent visits are arranged.

   There is no organized system of case finding.

3. Diagnostic and counselling services

   Only 13 diagnostic centres exist (in the following cities: Windsor, Cedar Springs, London, Woodstock, Guelph, Hamilton, Toronto, Orillia, Whitby, Kingston, Ottawa, Sudbury, and Thunder Bay).

   Other selected areas are served by travelling clinics.

4. Developmental care services for pre-school children

   Only 50 per cent of moderately, severely, and profoundly retarded children between the ages of three and five are in day nurseries.

5. Special education, training, and development services for school-aged children

   At present, there are provisions for programs for the trainable retarded in both community school boards and large institutions, but there is no obligation for community school boards to provide training services to the severely and profoundly retarded or for the Ministry of Education to provide these services in the institutions.

   Many school boards offer full day programs for trainable retarded persons; institutions provide

only half-day programs.

Only nine developmental day care centres (in Brampton, Brantford, Hamilton, Kitchener, Brockville, London, Thunder Bay, Ottawa, and North Bay), which are subsidized by the Ministry of Community and Social Services, provide substitute activity programs for this age group.

6. Continuing adult education services

No programs exist for the continuing education of retarded persons.

7. Vocational rehabilitation services

No assistance is provided for the integrated employment of retarded persons beyond the first year.

Less than 40 per cent of retarded adults on pension, excluding those in old age homes and nursing homes, are in a workshop program; a transfer of 10 per cent of the institutionalized population to the community will require an increase of 30 per cent in the workshop system.

There exists little financial incentive for a retarded person on a pension to get placed in marginal employment.

8. Daily activity for retarded adults

Some recreational activities are organized by each of the community residences and some are provided voluntarily by the Ontario Association for the Mentally Retarded; but there is no formal delegation of responsibility for this service.

9. Financial assistance

At present, the disability allowance for an

individual is $1,800 or $1,260 if boarding. If two retarded persons wished to marry, their combined pension would be $3,060, a reduction of 15 per cent.

10. Protective services

Each of the institutions assumes protective responsibility for its residents, but no responsibility is assigned for the retarded person in the community.

11. Medical services

The special needs of retarded persons for medical and special services are not always recognized.

12. Dental services

Provision for the retarded in the community is limited to several general hospitals where dental surgery is performed under anaesthesia; there are no arrangements for restorative and preventive work.

13. Spiritual services

Chaplaincy services are provided in institutions, but residents of community homes must make their own arrangements.

14. Residential care

Funding of residential care for the majority of the mentally retarded population is in the form of operating grants to institutions. Partial subsidy of community residences accounts for the remainder. There is no mechanism for funding apartments for retarded persons, group homes for the retarded, or foster homes for retarded adults (for periods longer than six months),

or for granting allowances to families with retarded persons.

If 10 per cent of the institutionalized population were to be moved into the community, the community residence program of the Ministry of Community and Social Services would need to be increased by 150 per cent.

At present, there is no legislation permitting the use of institutional operating grants for the provision of residences in the community.

15. Special treatment and training facilities

The retarded who also require nursing care are given high priority in admission to existing residential care programs.

At present, 350 persons who urgently require residential treatment and training services are waiting for admission.

APPENDIX II

Existing Legislation

The legislation will be reviewed within the fifteen categories of needs identified in Appendix I.

1. Preventive services

   Public Health Act:

   Helps reduce the incidence of mental retardation by promoting health education, particularly education related to infant nutrition, and by inspections by physicians and public health nurses

2. Case finding services

   Public Health Act:

   Permits inspection by public health nurses

   Child Welfare Act:

   Permits inspection by social workers from children's aid societies

   Schools Administration Act:

   Permits investigation after identification by teachers or other employees of schools

3. Diagnosis and counselling services

   Mental Hospitals Act:

   Permits the establishment of diagnostic and assessment clinics for the mentally retarded

   Children's Mental Health Centres Act:

   Permits the establishment of diagnostic and assessment clinics for emotionally disturbed children

4. Developmental care services for pre-school children

   Day Nurseries Act:

   Permits the subsidization of nursery schools for the retarded up to the age of 18 (if they do not qualify for programs offered by school boards)

5. Special education, training, and development services for school-aged children

Schools Administration Act:

Permits schools to offer special classes and services for the mentally retarded

Secondary Schools Act:

Permits school boards to offer special schools for the retarded

Public Schools and Separate Schools Acts:

Do not require school boards to provide instruction for those who will not benefit from their programs

Ministry of Education Act:

Permits the Ministry of Education to provide educational programs in institutions for the mentally retarded

6. Vocational rehabilitation services

Vocational Rehabilitation Services Act:

Permits the subsidization of workshops for the vocationally handicapped, including the mentally retarded, through grants, where a rehabilitation program is established:

(a) To enable a disabled person to become capable of pursuing regularly a substantially gainful occupation

(b) For assessment of the individual needs of a disabled person and for the formation of the vocational rehabilitation services likely to be required to meet his needs

Mental Health Act:

Permits institutions for the mentally retarded to provide vocational rehabilitation services

Employment Standards Act:

Permits the exemption of retarded persons from minimum wage laws, both in sheltered workshops and in outside industry

7. Daily activity for retarded adults

Ministry of Education Act:

Permits the awarding of grants to non-profit camps

Mental Health Act:

Permits the provision of recreational programs in institutions for the mentally retarded

8. Financial assistance

Family Benefits Act:

May provide benefits to disabled persons, including the mentally retarded, unless they receive an old age pension or are residents of an institution or a home for special care

General Welfare Assistance Act:

May provide assistance to persons in need, including the retarded

Canada Pension Plan:

Provides financial assistance to the aged, including the retarded

Vocational Rehabilitation Services Act:

May provide an allowance to persons in training at a workshop who are not eligible for family benefits (retarded persons usually do not qualify)

9. Protective services

Mental Incompetency Act:

Creates a committee of estates for persons found to be mentally incompetent by a court

Child Welfare Act:

Permits children's aid societies to accept care and custody for children unless they are placed in an institution

Mental Health Act:

May provide institutions that have control over the retarded person placed in them

10. Medical services

Ontario Hospital Insurance Plan:

Provides medical and hospitalization insurance for persons on family benefits, including the mentally retarded

Mental Health Act:

Provides medical services to residents of an institution for the retarded

11. Dental services

Mental Health Act:

Permits the provision of remedial and ordinary dental services to residents of an institution

12. Spiritual services

Mental Health Act:

Permits the provision of chaplaincy services for residents of an institution

13. Residential care

Mental Health Act:

Permits per diem payments to private facilities for the profoundly retarded

Permits the admission of mentally retarded persons to institutions for the mentally retarded

Mental Hospitals Act:

Permits the admission of a mentally retarded person to a psychiatric hospital

Permits the placement of a retarded person in an approved home for up to six months after discharge from an institution

Homes for Retarded Persons Act:

Permits the provision of grants for 50 per cent of capital and 80 per cent of operating costs to community residences for the retarded

Children's Institutions Act:

Permits the provision of grants for 50 per cent of capital and 80 per cent of operating costs to residences for troubled children and youths, including the retarded

Children's Boarding Homes Act:

Makes regulations for the operation of residences for children (many of these residences are for retarded children)

Homes for the Aged and Rest Homes Act:

Permits the support of municipal homes for the aged, including the mentally retarded

Charitable Institutions Act:

Permits the provision of grants for 50 per cent of capital and 80 per cent of operating costs to charitable institutions providing residences for troubled youths and children or the aged, including many retarded persons

Child Welfare Act:

Permits the provision of residential care to children in need of protection by children's aid societies, including retarded children

Homes for Special Care Act:

Permits the provision of both nursing homes and residential homes for the mentally retarded

14. Special treatment and training facilities

Mental Health Act:

Permits the provision of special treatment for retarded persons

Homes for Special Care Act:

Permits the provision of special treatment for persons, including the retarded

Appendix III

Present Care System

The following list summarizes the major roles of the six ministry branches and agencies which provide services for the retarded.

1. Ministry of Health
   (a) Mental Retardation Services Branch:
   - supervision and operation of the 13 diagnostic and assessment centres
   - supervision and operation of 10 institutions for the retarded
   - financing of 8 facilities for profoundly retarded young children (these facilities are operated by independent, local boards)
   - coordination of and liaison with community agencies providing supportive services to the retarded both in and out of residential care
   - discretionary power to purchase up to six months of boarding home care for a retarded person

   (b) Psychiatric Services Branch:
   - admission and care of mentally retarded persons in non-retardation units of psychiatric hospitals
   - discretionary power to purchase up to six months of boarding home care for a retarded person
   - supervision and operation of three units for mental retardation in psychiatric hospitals

   (c) Special Health Services Branch:
   - support of 14 designated nursing homes for the retarded

admission of retarded persons to both nursing and residential homes on discharge from a psychiatric facility

(d) Local Health Services Branch:
provision of case finding and home support services through public health nurses

(e) Mental Health Foundation:
support of clinical and operational research related to mental retardation
support of pilot projects

2. Ministry of Education
(a) Grants to Local Boards:
provision of special classes and programs for the educable retarded (school boards are expected to provide these services within their normal per-pupil budgets)
provision of schools for the trainable retarded (schools for the trainable retarded between the ages of 6 and 21 are funded at the secondary student rate of $1,130 per pupil; the Province pays only 58 per cent of this amount)

(b) Provincial Schools Branch:
by agreement with the Ministry of Health, provision of education programs directly to educable and trainable retarded persons in institutions for retarded persons operated by the Ministry of Health

3. Ministry of Colleges and Universities
(a) Universities:
education of psychologists and psychiatrists,

teachers, social workers, and other professional staff

(b) Colleges of Applied Arts and Technology:
education of nurses, day care workers, and residential counsellors

4. Ministry of Community and Social Services

(a) Child Welfare Branch:
support of 51 children's aid societies to provide for children in need (the incidence of retarded children on their caseload is much higher than the incidence in the general population)

(b) Children's and Youth Institutions Branch:
provision of grants of 50 per cent of capital costs for 21 community residences for retarded persons
regulation of community residences for retarded persons
provision of grants of 50 per cent of capital costs and 80 per cent of operating costs to charitable institutions and children's institutions (the incidence of retarded persons in these institutions is estimated to be 25 per cent of their population, significantly higher than in the general population)
regulation of children's boarding homes, children's institutions, and charitable institutions

(c) Day Nurseries Branch:
provision of grants of 50 per cent of capital

costs and 80 per cent of operating costs to nursery schools and developmental day care centres for retarded children

regulation of nursery schools and day care centres for retarded children

(d) Family Benefits Branch:

provision of social assistance to disabled persons who are not eligible for old age pension (retardation is one of the principal disabilities)

(e) Vocational Rehabilitation Services Branch:

support of workshops for the vocationally handicapped through capital and operating grants (a large fraction of the vocationally handicapped are retarded)

provision of assessment, counselling, training, and placement services for the vocationally handicapped, including the retarded

(f) Municipal Welfare Administration Branch:

sharing with the municipalities and Indian bands of the costs of short-term assistance to persons (both employable and unemployable)

(g) Homes for the Aged Branch:

support of intermediate and extended care in municipal and charitable homes and foster homes (the incidence of retarded in this population is larger than that in the general population)

5. Ministry of the Attorney-General

Office of the Official Guardian and Public Trustee:
supervision of estates and contracts on behalf of retarded persons

6. Ministry of Labour
Employment Standards Branch:
authorization of employment of handicapped persons (with consent) at a wage lower than the regulated minimum wage

Usage of Present Programs

This section examines the distribution of retarded persons among the various programs, including a residual program of no service in all cases, within the following age categories:

1. Adults (18 years and older)
2. School-aged children (5 to 17 years)
3. Pre-school children (under 5).

1. Programs for Adults

(a) Population of Retarded Adults

About 0.3 per cent of all adults in Ontario are supported by one or more of the several programs of the Government of Ontario. (Some are supported in workshop and community residence programs as well as receiving a disability allowance.) For the purposes of estimating the number of retarded adults presently served, the following were included:

All retarded adults in institutions for the mentally retarded and in psychiatric hospitals

All retarded adults in homes for special care (they receive board allowance from family benefits, but no comfort allowance)

All retarded in homes for the aged on old age pension

All retarded persons receiving family benefit allowance (estimated)

Table III-1 Survey of Retarded Adults, 1972

Program	Number reported in 1972	Percentage of total
Institutions for the mentally retarded	4,030	23.3
Psychiatric hospitals	1,594	9.2
Homes for special care	830 (est.)	4.8
Homes for the aged (no disability allowance)	569	3.3
Disability allowance (FBA)	10,300 (est.)	59.5
Total	17,323	100.0%

(b) Subsidized residential care

Approximately 47 per cent of identified retarded adults receive directly subsidized residential care in the following types of facilities:

Institutions for the mentally retarded

Psychiatric hospitals

Nursing homes for special care

Residential homes for special care

Community residences for the retarded

Homes for the aged

Table III-2 Subsidized Residential Care for Retarded Adults, 1972

Program	Estimated number of residents	Percentage of all subsidized residents	Percentage of identified retarded adults
Institutions for the mentally retarded	4,030	49.5	
Psychiatric hospitals	1,594	19.6	
Nursing homes for special care	830	10.2	
Residential homes for special care	420	5.2	
Community residences for the retarded	156	1.9	
Homes for the aged	1,117	13.7	
All in subsidized residences	8,147	100.0	47
All in unsubsidized residences	9,176		53
Total	17,323		100

(c) Activity and occupational programs

Approximately 40 per cent of identified retarded adults participate in subsidized activity or occupational programs through the following:

Institutions for the mentally retarded

Units for the mentally retarded in psychiatric hospitals

Sheltered workshops

It may be noted that sheltered workshops also perform a training function to prepare some of those attending for employment outside the workshop; this number is estimated at roughly 10 per cent.

Table III-3 Subsidized Activity and Occupational Programs for Retarded Adults, 1972

Program	Number enrolled	Percentage of total enrolment	Percentage of identified retarded adults
Institutions for the mentally retarded:			
adult training	1,171	16.8	
activity units	2,723	39.1	
Units in psychiatric hospitals	400	5.8	
Rehabilitation workshops	2,663	38.3	
Total All Participants	6,957	100.0	40
Non-participants	10,366		60
Total	17,323		100

(d) Guardianship and protection services

The institutions and psychiatric hospitals, as closed systems, perform a guardianship function. No corresponding service exists in the community. The proportion covered is 33 per cent.

Table III-4 Guardianship and Protection Services for Retarded Adults, 1972

Program	Number protected	Percentage of protected adults	Percentage of identified retarded adults
Institutions for the mentally retarded	4,030	71.7	
Units in psychiatric hospitals	400	7.1	
Others in psychiatric hospitals	1,194	21.2	
All under protection	5,624	100.0	33
All unprotected	11,699		67
Total	17,323		100

2. Programs for School-Aged Children

(a) Population of school-aged retarded children

For purposes of estimation of the number of school-aged retarded children who are currently served, the following services were summed:

Institutions for the mentally retarded
Schedule II facilities
Developmental day care centres (but not nursery schools)
Schools for the trainable retarded
Classes for the educable retarded

Table III-5 Survey of School-Aged Retarded Children, 1972*

Program	Number of retarded	Percentage of total
Institutions for the mentally retarded	3,000	7.9
Schedule II facilities	520	1.4
Developmental day care centres	390	1.0
Schools for the trainable retarded	5,697	15.0
Classes for the educable retarded	28,238	74.6
Total	37,845	100.0

* Since a retarded child need not be admitted by a school board to its school for the trainable retarded, when the board considers that the child will not benefit from its instruction, and since developmental day care services for school-aged children are not universally available, there are some retarded children who are not identified in this table.

(b) Subsidized residential care

Subsidized residential care for school-aged retarded children is provided through the following services:

Institutions for the mentally retarded

Community residences

Foster homes (through children's aid societies)

Nursing homes for special care

Residential homes for special care

Schedule II facilities for the profoundly retarded

Children's and charitable institutions for troubled children

Table III-6 Subsidized Residential Programs for School-Aged Retarded Children, 1972

Program	Number of residents	Percentage of all subsidized residents	Percentage of identified school-aged retarded children
Institutions for the mentally retarded	3,000	56.2	
Community residences	149(est)	2.8	
Foster homes (through CAS)	558	10.5	
Nursing homes for special care	560(est)	10.5	
Residential homes for special care	210(est)	3.9	
Schedule II facilities	520	9.7	
Children's and charitable institutions	200(est)	3.8	
Children's boarding homes	140	2.6	
All in subsidized residences	5,337	100.0	14
Classes for educable retarded	28,238		75
All in unsubsidized residences	4,270		11
Total	37,845		100

(c) Education

Education for school-aged retarded children is provided through the following services:

Provincial schools in the institutions for the retarded

Schools for the trainable retarded operated by school boards

Developmental day care centres for retarded children between the ages of 6 and 18

Special programs for the educable retarded in community schools

Table III-7 Education Services for School-Aged Retarded Children, 1972

Service	Enrolment	Percentage of total enrolment	Percentage of all eligible
Provincial schools in institutions	1,403	18.7	
Schools for the trainable retarded	5,697	76.1	
Developmental day care centres	390	5.2	
All participants	7,490	100.0	20
Classes for the educable retarded	28,238		75
Non-participants	2,117		5
Total	37,845		100

(d) Guardianship and protection services

Guardianship and protective services are provided for most retarded children by their parents. For the others, they are provided by:

Institutions for the mentally retarded

Schedule II facilities

Children's aid societies

Table III-8 Guardianship and Protection Services for School-Aged Retarded Children, 1972

	Number protected	Percentage of protected children	Percentage of identified school-aged children
Institutions for the mentally retarded	3,000	70.7	
Schedule II facilities	520	12.3	
Children's aid societies	721	17.0	
All under protection	4,241	100.0	11
All unprotected	33,604		89
Total	37,845		100

3. Programs for Pre-school Children

(a) Population of pre-school retarded children

No universal program exists for pre-school retarded children. Therefore, in the survey of pre-school children, the same proportion is used as for school-aged retarded children.

Table III-9 Estimate of Pre-School Retarded Children, 1972

Age group	Population served	Total population	Percentage of total population
Pre-school	15,600	780,000	2.0
School-aged	37,845	1,900,000	2.0

(b) Subsidized residential care

Relatively few pre-school children are under residential care. The most common case is that of the profoundly handicapped, who are received into Schedule II facilities or hospital units of the institutions for the mentally retarded.

Table III-10 Subsidized Residential Care for Pre-school Retarded Children, 1972

Service	Number of Residents	Percentage of all subsidized residents	Percentage of identified pre-school retarded children
Schedule II facilities	50	17	
Institutions for the mentally retarded	190	64	
Children's boarding homes	55	19	
All in subsidized residences	295	100	2
All in unsubsidized residences	15,305		98
Total	15,600		100

(c) Day care

Nursery schools for pre-school retarded children are subsidized under The Day Nurseries Act.

964 pre-school children in these nursery schools constitute 25 per cent of all pre-school children who are moderately, severely or profoundly retarded.

(d) Guardianship and protection services

Again, these services are provided for most pre-school children by their parents. In other cases, they are provided by institutions for the mentally retarded, Schedule II facilities, and children's aid societies.

Appendix IV

Survey of Costs

Costs of Present Programs for the Mentally Retarded

The allocation of total resources will be described under two classifications: ministry and branch (Table IV-1), and category of care (Table IV-2).

Table IV-1 Budget According to Branch and Ministry, 1971-72

Ministry	Branch	Estimated spending ($/1,000)	Percentage
Health	Mental Retardation Services	$ 60,680	40.8
	Psychiatric Services	14,000	9.4
	Special Health Service	7,100	4.8
	Local Health Services	1,900	1.3
	Subtotal	$ 83,680	56.3
Education	Classes for educable retarded	$ 23,466	15.8
	Schools for trainable retarded	12,864	8.6
	Hospital schools	2,759	1.9
	Subtotal	$ 39,089	26.3
Community and Social Services	Child Welfare	$ 4,771	3.2
	Children's Institutions	1,119	0.8
	Day Nurseries	273	0.2
	Family Benefits	12,651	8.5
	General Welfare	1,580	1.1
	Vocational Rehabilitation	859	0.6
	Homes for the Aged	2,600	1.8
	Subtotal	$ 23,853	16.0
Government Services	Maintenance and Repair	$ 2,154	1.5
Total		$148,776	100.0

Table IV-2 Budget According to Category of Care, 1971-1972

Service	Total spending ($/1,000)	Percentage
*Preventive services		
Case finding:		
public health nurses	$ 1,900	1.3
Diagnosis and counselling	4,000	2.7
Developmental care	273	0.2
Special education	39,089	26.3
	$ 45,262	30.4
Vocational rehabilitation and job placement		
community	859	0.6
institution	473	0.3
Rehabilitation subtotal	$ 1,332	0.9
*Recreation		
Financial assistance	14,231	9.6
Protection services		
*Medical services		
Dental services	172	0.1
Spiritual services	43	
Residential care and Counselling:		
institutions	$ 58,146	39.1
psychiatric hospitals	14,000	9.4
homes for special care	7,100	4.8
community residences apartments and group homes	1,119	0.8
foster care of children	4,771	3.2
homes for the aged	2,600	1.8
Residential Subtotal	$ 87,479	57.8
	$148,776	100.0

* Costs for these categories cannot be identified separately.

Unit Costs of Programs for the Retarded

Table IV-3 presents the typical annual cost of caring for an individual in different settings and identifies the key variable for effecting cost reduction at that type of institution. Table IV-4 presents the actual operating costs of some of the facilities for retarded persons.

Table IV-3 Costs of Several Services to the Retarded, 1971-1972

Service	Key variable	Gross costs per person per year	Federal-provincial cost-sharing
Institution	Resident:staff ratio		
	0.88(Palmerston)	$10,642	100 per cent province
	1.08(Edgar)	9,144	
	1.28(Orillia)	6,760	
Community residence with counsellors	Resident:staff ratio		
	2.0	5,000	possible sharing under Canada Assistance Plan
	3.0	4,200	
	4.0(legal requirement)	3,500	
Apartment	Monthly rent per person		
	$57(family benefit allowance)	684	50 per cent of family benefits shared under Canada Assistance Plan
	$78	936	
Workshop	Weekly wages of retarded		50 per cent of province costs sharable under Vocational Rehabilitation Act
	$4.50(current)	1,500	

(continued)

Table IV-3 Costs of Several Services to the Retarded, 1971-1972 (continued)

Service	Key variable	Gross costs per person per year	Federal-provincial cost cost-sharing
Allowance	Single person	$ 1,620	50 per cent shared under Canada Assistance Plan
	Couple(per person)	1,218	
	Comfort allowance	300	
Counselling	Caseload (clients per staff)		
	2	4,000	50 per cent sharable under Canada Assistance Plan
	4	2,000	
	10	800	
	40	200	

Table IV-4 Annual Per Capita Operating Costs, 1972*

Facilities for the retarded	Average number of residents	$ per Resident
Picton	243	11,370
Palmerston	235	10,642
Edgar	250	9,144
Aurora	215	8,271
Cobourg	293	8,218
Smiths Falls	2,068	7,317
Cedar Springs	1,165	7,163
Orillia	2,206	6,760
Gravenhurst	408	6,165
Total	7,083	7,420
Homes for retarded persons		
Charleston, Caledon	15	9,906
Good Shepherd, Orangeville	28	8,242
Meadowcrest, Ailsa Spring	12	6,121
Glengarda, Windsor	28	5,676
Sheppard Avenue, Toronto	26	5,639
Rosedale, Fort Erie	10	5,585
Daybreak, Richmond Hill	24	5,435
Friendship, St. Thomas	24	5,110
Grandview, Chelmsford	10	5,052
Harold Lawson, Scarborough	50	4,909
Scott House, London	11	4,767
Arcwood Acres	14	4,672
Hawthorne, Pt. Colborne	18	4,062
Silver Springs, Ottawa	38	3,829
Churchwood, Windsor	19	3,756
Hamilton Association Residence	11	2,405
Total	338	4,879

* Second quarter estimates

Appendix V

References and Principal Recommendations of Other Studies

Principal Suggestions of the Williston Report*

1. The use of large institutions for the mentally retarded should be phased down, but this system of care services should not be disbanded entirely. Following are some of the reasons for seeking alternatives to institutionalization:

   Wards are severely overcrowded, and many are locked unnecessarily.

   Persons of different ages, degrees of retardation, and varied handicaps are placed together.

   There is a lack of privacy.

   Admission usually means that custodial care is emphasized rather than training or rehabilitation.

   There is a lack of contact between the retarded person and his family since residents are drawn from a large geographical area.

   Institutions are isolated from the rest of the community.

   There is insufficient staff.

   Many buildings constitute fire hazards.

* "Present Arrangements for the Care and Supervision of Mentally Retarded Persons in Ontario" W.B. Williston, Ontario Ministry of Health, August, 1971.

Institutions are not an economical way of providing custodial care.

Institutions are too remote from universities or other centres of higher learning.

Institutions force retarded persons to function far below their development potential, and they inhibit rehabilitation by failing to provide social contacts.

Residents are paid unrealistic wages for their work. After they leave the institution, they have little concept of the value of money since they have had no practice in its use.

The Ontario Hospital School system is divorced from the mainstream of health, education, and social and family services. It thus cannot adequately establish and administer services that are responsive to community needs.

There are many problems that restrict community involvement with larger hospital institutions.

2. By limiting admissions (to perhaps 40 per cent of present enrolment) and by exerting a greater effort to rehabilitate those who could return to the community, institutions could play an important role:

For nursing or medical care (for example, caring for severely retarded persons)

For behaviour modification or correction (intensive care may be required to break obnoxious habits)

For crisis intervention (when parents require short-term relief)

For training parents and staff of residential facilities

For research

3. If possible, every mentally retarded child should be with his family. The following conditions, however, are essential:

   Parents must be provided with necessary support services.

   The home must provide a satisfactory environment.

   The child should be only mildly or moderately retarded.

   The child should have no behavioural or emotional problems that require expert care and assistance.

4. A moderately retarded adult should be in a sheltered home close to a sheltered workshop. The range of services in the community must be such that the family can be certain that the retarded person will be properly looked after when he leaves home, and it should include some guardianship arrangement.

5. It is more economical and humanitarian to give the retarded person the total care he needs in his own community rather than provide for it in an institution. As long as the retarded child remains at home, the parents should receive all the help they need to support him there, whether it be material, financial, medical, dental, psychological, or social. The ability of the community to care for mentally retarded persons within its boundaries depends upon the quality and quantity of family support, crisis intervention

services, rehabilitation services, and educational, vocational, and recreational opportunities.

6. It may not always be possible for parents to keep a mentally retarded child at home. In this case, small living units should be provided. It is vital that the community residence be a home to those who reside in it. These are some of the desirable ingredients of community-based residences:

   They should be easily accessible to persons in all geographical areas and close to public transportation. They should be so distributed that the majority of residents are located as near home as possible. This dispersal will encourage rehabilitation and allow the placement of residents close to employment opportunities.

   Each residence should be situated in the midst of a community, in or near population centres.

   The residences should conform to other types of family accommodation located in the area.

   There should be maximum socialization between staff and residents.

   Residences must be integrated with educational, recreational, and commercial facilities in the area.

   They should draw on the professional resources of the communities in which they are centred.

   One or more of eight types of residence may be provided in the community:

Specialized foster homes

Long-term residences for children

Temporary specialized boarding homes for children

Residential treatment centres

Supervised long-term residential houses for adults

Apartments and cooperative housing

Half-way houses

Chronic care facilities

Smaller residential facilities offer the following advantages:

They are more humane.

Mentally retarded persons can be more easily integrated into society.

They are inexpensive as compared with an institution.

They require no heavy capital expenditures.

The system can be put into operation with facility and speed.

Financial assistance can be obtained from the federal government.

7. The following services should be provided in local communities throughout the province:

Home visiting and counselling services

Direct financial assistance

Short-term crisis relief

Day nurseries

Day care centres

Special day care services for children who are unable to benefit from day care centres

Day care centres for retarded adults

Specialized homemaker services

Qualified babysitters

Foster grandparents

A neighbourhood social work team

Guardianship services

Pre-natal counselling

Citizen advocacy (pairing the retarded person with a non-retarded volunteer)

Dental service

Employment services (it is imperative to open up new fields by developing the potential of the mentally retarded)

To ensure that the mentally retarded person functions to his full occupational potential, there need be

Vocational rehabilitation service agencies

Vocational training programs

Sheltered workshops

Sheltered employment

8. A comprehensive centre for research, diagnosis, medical treatment, and counselling is necessary to keep the number of mentally retarded in the community from increasing.

(a) Research. Biomedical research in the fields of diagnosis, prevention, and treatment, as well as sociological, psychological, and behavioural investigations, must be an integral part of the whole operation.

(b) Diagnosis and assessment. It is important to identify the problem at an early age to help the child before he reaches school. There must be a multi-disciplinary assessment centre where the nature of the patient's problems is determined and considered. A medical history of child and parent should be completed. There should be a physical examination and a psychological and social evaluation made.

(c) Family counselling services. These should be available for parents and their advisors. The service should provide medical advice, genetic counselling, pre-school counselling, a directory of services, referral to appropriate services, and information about mental retardation.

(d) Hospital facilities. There should be a hospital ward available in connection with the centre to provide care, research, and training. There must be facilities for acute medical care, observation, and diagnosis. These hospitals should not be places for chronic care.

(e) Location of centre. Research should be conducted at a centre attached to a hospital in a university town, since this is where people with specialized skills in multi-disciplinary fields are located.

9. A centralized computer system is essential for meaningful planning, coordination of service, delivery of services, and research. Such a centralized system should have appropriate communication terminal devices located in each of the regional centres throughout the province.

10. There is an absence of centralized planning and responsibility in Ontario. No single department or service has a clearly defined responsibility for handicapped persons. Since there is no overall planning or centralized budgeting, there can be no assurance that total government expenditures on the mentally retarded will be used in the most effective and efficient way. It is essential that there be a centralized planning office through which the various services to the handicapped can be conducted. The most effective way to accomplish this objective would be to make one department responsible for services to all handicapped persons and their families. The department would have responsibility for:

    Standards of services, personnel, and programs through legislation or regulation

    Evaluating and recommending disposal of funds that are devoted to facilities for handicapped persons (central budgeting, not necessarily total financing)

    Implementation of standards with inspections to ensure that standards are maintained

    Coordinating the planning and service delivery in all areas.

Development of technical personnel to assist in planning, operation, and evaluation

Coordination of mental retardation services and research

It is recommended that a department be established, headed by a person with Cabinet authority, to take over planning, coordination, and centralized budgeting. If this proposal is unacceptable to government, one senior minister may be appointed to coordinate all departmental responsibilities in this field.

Decentralization is essential if the services are to be readily available at the point of need.

11. Centralized planning at the government level must be implemented through regional centres whose orientation is directed towards the community. Only through the development of a network of services within the community that are coordinated with education, health, and social and family services will the needs of the mentally retarded be adequately fulfilled.

Ontario should be divided into zones, on the basis of area and population; ideally, the centre should be situated in a populous area and no person (in most cases) should have to travel more than 100 miles to reach the centre. It would also be helpful if the centre were located in a university town so that the facilities of the the university could be used for research and staff training.

At the centre of each zone should be

An advisory board or social planning council composed mainly of citizens residing within the zone who would be responsible for the total planning of services for the mentally retarded. It would approve and control the use of government funds.

An executive officer and staff

A diagnostic centre, affiliated with a hospital, including a comprehensive health clinic and a travelling unit

A data collecting service to maintain records of all mentally retarded persons in the area. Each computer should be connected with a central computer.

An advisory or referral service to counsel parents and the handicapped for the purpose of recommending services available to them.

12. Initially, the centre might deal only with problems of the mentally retarded. Later it could take over the problems of all the handicapped and thus avoid duplication of facilities. Dispersed throughout the zones there must be the following:

Domiciliary facilities

Small community residences
Foster homes
Group homes
Apartments
Hostels, short-term residences and drop-in centres
Nursing homes
Half-way houses
Boarding houses

Community care facilities

- Nurseries
- Day care centres (for children and adults)
- Vocational training, sheltered workshops
- Clubs
- Recreational facilities and opportunities
- Camps
- Sheltered employment
- Vocational rehabilitation agency for training placement

Community services

- Social and family counselling services for both the retarded person and his family
- Home care and nursing services
- Home visiting services
- Guardianship services
- Programs for activity and recreation

13. The management and delivery of services planned for each zone must be provided by units located within the zone. Almost all facilities under the ministries of Health and Community and Social Services can be used, but they must be coordinated and, in some cases, amalgamated. At present, since the Ontario Association for the Mentally Retarded has the expertise, knowledge, and experience, it is reasonable to give this body a major share in the responsibility for the management and delivery of the services. The Association might have to reorganize and coordinate local associations within the zone into one association with a series of local units.

14. Finally, it is unnecessary for the government to build or operate residences, workshops, or leisure facilities in the communities. It would be more appropriate for the government to increase economic support to organizations that are providing these services.

RECOMMENDATIONS OF THE NORTHEASTERN ONTARIO TASK FORCE*

There should be established, by appropriate provincial agencies and subject to their jurisdiction, accredited training courses for homemakers, houseparents, foster parents, residential counsellors, and day care and workshop staff.

A transportation allowance should be incorporated as an accepted operating cost of any approved program.

Community residential facilities

The Homes for Retarded Persons' Act should be amended as follows:

Capital grants should be increased to 100 per cent of approved capital costs, including land.

* "Recommendations on Mental Retardation Services and Programs in Northeastern Ontario" Task Force on Mental Retardation Needs and Services - Northeastern Ontario, Part 1 - December, 1971, Part 2 - April, 1972

Operating grants should be increased to 100 percent for children under 18 years.

Construction regulations should be reviewed to encourage a more homelike environment.

Existing residences should be renovated to encourage development within the residential community.

A boarding home or foster home program should be instituted by local associations with financial support similar to the Approved Home Program (Mental Hospitals Act).

Day care

Day nursery legislation should be amended to recognize local associations as the sponsoring body.

Capital grants should be made available for 100 percent of the total approved cost, including land.

Operating grants should be increased to 80 percent of the approved operating costs.

Maximum age restrictions should be eliminated to permit any retarded person to attend a day care program regardless of age.

Day care programs should be operated on a year-round basis.

An adult activity program should be established as part of a day care program as an alternative to placing seriously retarded in institutions.

Education

The Ministry of Education should provide summer programs, increased bilingual instruction, and home instruction units.

Workshops

The following amendments should be made to the Vocational Rehabilitation Act:

Capital grants should be increased to 80 per cent of approved capital costs, including land, and should be made retroactive to cover mortgages on existing workshops.

Operating grants should be increased to 80 per cent of approved operating costs.

The staff of the Vocational Rehabilitation Services Branch should be increased.

Summer camps

A $1.00 per day per camper grant should be made available through the Ministry of Education (Youth and Recreation Branch).

Direct financial family assistance

The family benefits allowance should provide direct financial assistance to parents of handicapped persons regardless of age, and allowable earnings by the handicapped should be increased.

Legal services

Legislation should be considered establishing guardianship and citizen advocacy, and defining the legal status of retarded persons.

Regional board

Four boards should be established, each comprised of 10 to 20 members, with 50 per cent from local associations for the mentally retarded and 50 per cent from the provincial Ministries of Education, Health, and Community and Social Services, and community agencies and community representatives.

Boards should not be directly involved in the delivery of services.

The responsibilities of the boards should include planning, coordination, and recommendations to government regarding funding of mental retardation programs.

An appeal procedure should be established in the event of adverse recommendations from the boards.

The annual budget must be approved (including "out-of-pocket" expenses for board members, and supportive staff salaries and expenses).

These recommendations should be accepted by the Ontario Association for the Mentally Retarded in order that regional councils of the OAMR could assume role of regional boards.

The task force and subcommittees should not be disbanded until the boards are recognized as a functioning identity.

Recommendations not requiring regional boards for immediate implementation

Diagnosis and assessment

Government-financed diagnostic and assessment services should be established in North Bay,

Porcupine, and Sault Ste. Marie.

The existing program at the Sudbury Algoma Sanatorium should be reinforced with increased professional and clerical staff.

Diagnostic and assessment services and screen referrals should be coordinated in all four areas by the public health units.

Short-term treatment

Government-financed, short-term treatment facilities should be established as follows:

North Bay	- 15 beds	(part of the comprehensive care centre)
Porcupine	- 25 beds	(part of the diagnostic and assessment unit at Northeastern Mental Health Centre)
Sault Ste. Marie	- 15 beds	(part of the comprehensive care centre)
Sudbury	- 40 beds	(part of the mental retardation program at the Sudbury Algoma Sanatorium);

The short-term treatment facilities in Sudbury should be expanded to 120 beds to provide back-up services to all four areas.

RECOMMENDATIONS

Requiring Establishment of Regional Board Prior to Implementation of Community Facilities

WE RECOMMEND the establishment of community facilities as follows:

Residential

Area	Interim Units	Interim Accommodation	Total Units	Total Accommodation
North Bay	6	48	10	90
Porcupine	8	80	11	110
Sault Ste. Marie	7	70	9	90
Sudbury	5	50	12	120

Day care

Area	Interim Units	Interim Accommodation	Total Units	Total Accommodation
North Bay	1	36	4	100
Porcupine	2	50	6	150
Sault Ste. Marie	2	60	4	125
Sudbury	2	80	5	200

Workshops

Area	Interim Units	Interim Accommodation	Total Units	Total Accommodation
North Bay	4	75	4	128
Porcupine	6	120	7	175
Sault Ste. Marie	2	75	4	150
Sudbury	4	164	5	264

Summer camp

Area	Units	Accommodation
North Bay	1	75
Porcupine	1	25
Sault Ste. Marie	1	50
Sudbury	1	100

PROJECTED COST FACTORS

Recommended services	Interim program			Total program		
	Capital cost	Operating cost	Numbers served	Capital cost	Operating cost	Numbers served
Regional board					250,000	
Diagnosis and assessment						
Short-term care	1,432,000	1,050,000	734	3,032,000	1,820,000	974
Long-term care		170,000	42	4,400,000	2,665,000	435
Community residential facilities	2,700,000	990,000	334	4,450,000	1,640,000	533
Day care	492,000	492,000	270	1,150,000	1,150,000	632
Workshops	1,085,000	650,000	434	1,800,000	1,080,000	717
Summer camp					3,000	250
Direct financial family assistance		148,000	246		355,000	575
	$5,709,000	$3,500,000	2,060	$14,832,000	$8,963,000	4,116

400-bed residential unit

Total Program

Capital cost	Operating cost	Numbers served
$8,000,000	$2,920,000	400

Comparison of costs

	Capital cost per individual served	Operating cost per individual served
Recommended services		
Interim program	$ 2,820	$1,700
Total program	3,600	2,200
400-bed residential unit	20,000	7,300